

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1.
 - a. Whether there should be reimbursement for date of service 06/14/01.
 - b. The request was received on 06/14/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC-60
 - b. HCFA-1500
 - c. TWCC-62 forms
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC-60
 - b. HCFA-1500
 - c. TWCC-62 forms
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. The case file does not contain additional information from the provider as required by Rule 133.307 (g) (3). The additional information was requested from the provider by the Division on 07/11/02. The response received from the carrier was received in the Division on 06/24/02 and is reflected in Exhibit II. All information in the medical dispute packet will be reviewed.

III. PARTIES' POSITIONS

1. Requestor: No Response
2. Respondent: No Response

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 06/14/02.
2. Per the provider's TWCC-60, the amount billed was \$375.00; the amount paid was \$0.00; the amount in dispute is \$375.00.

3. The carrier denied the billed services by codes:
 “F – Reduced According to Fee Guideline”;
“No additional amount recommended at this time. A. Initially allowed at Fair and Reasonable not Usual & Customary per other EOB’s attached. B. TWCC does not have a DME F&R rate in place, which make [sic] your attached obsolete. C. Documentation does not address if its a rental or purchase. We believe that it was allowed at a F&R. If you still disagree please provide this office with a cost invoice.”
4. Both the carrier and the provider submitted TWCC-62 forms dated 08-02-01/08-23-01, 04-18-02/06-02-02, and 04/23/02 indicating \$150.00 was paid for code E2035 and \$106.25 was paid for code E1399. The carrier submitted a payment screen in the response which confirmed that the provider was reimbursed a total of \$256.25 for disputed date of service 06/14/01. At the bottom of the carrier’s TWCC-60, a note was written stating, “The recommended allowance was: \$256.25, which was paid on 06/02/02. Please see attached documentation.”
5. In a telephone call on 11/14/02, the provider representative confirmed the provider received a check for \$256.25 on 06/25/02 and another check for \$11.00 on 08/28/02 for a total reimbursement of \$267.25. The adjusted amount in dispute per the provider is \$107.75 and she wants to pursue the dispute.
6. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
06/14/01	E0235 D0366	\$250.00	\$150.00	F, F&R	D0366 purchase = \$225.00; rental = \$30.00	CPT descriptor; Rule 133.307 (g) (3); (A), (B), (C); MFG DMEGR (II), (IV), (VI), (VIII), (IX)	The provider failed to respond to the request for additional information mailed on 07/11/01, therefore, no medical documentation is included in the medical dispute packet to indicate that the services were rendered as billed. The provider failed to indicate whether the DME was for purchase or rental. There is no description of the unlisted equipment or supply for the E1399 code. There is no itemized list for code E1399. “A statement of medical necessity, along with the order or prescription appropriate for the equipment /supplies shall accompany initial claims for the rental or purchase of DME.... This statement shall include the medical necessity and specify the following:... claimant’s diagnosis;...prognosis...the expected duration the equipment or supplies will be required.” The provider failed to submit the statement of medical necessity for both billed “E” codes.
06/14/01	E1399	\$125.00	\$106.25 extra check received on 08/28/02: \$11.00 from carrier	F, F&R	DOP		
Totals		\$375.00	\$267.25				No reimbursement is recommended The Requestor is not entitled to reimbursement.

The above Findings and Decision are hereby issued this 18th day of November 2002.

Donna M. Myers
 Medical Dispute Resolution Officer
 Medical Review Division